Renewal Fitness Program Screening Form / Medical Clearance

Last Name _____ First Name _____ DOB _____

Address _____ City_____ State____ Zip_____

Phone _____ Mobile _____ Email _____

Age_____ Female_____ Male_____ Height_____ Weight_____

MEDICAL HISTORY (Please circle the appropriate response)

Have you had any major injuries / surgery during the last three years? **YES/NO**

If yes, please list _____

Have you ever suffered from the following?

- Arthritis / RA / joint pain **YES / NO**
- Asthma / breathing problems **YES / NO**
- Circulation problems **YES / NO**
- Diabetes **YES / NO**
- Dizziness **YES / NO**
- Heart condition / surgery **YES / NO**
- Hernia **YES / NO**
- High blood pressure **YES / NO**
- High cholesterol / triglycerides **YES / NO**
- Knee / hip replacement **YES / NO**
- Liver / kidney condition **YES / NO**
- Lower back pain **YES / NO**
- Pacemaker **YES / NO**
- Pain / tightness in the chest **YES / NO**
- Stroke **YES / NO**
- Thyroid problem **YES / NO**

MEDICATIONS: Please list your current medications below.

_____ _____ _____ _____

_____ _____ _____ _____

- Do you consider your diet to be: **GOOD**___ **ADEQUATE/APPROPRIATE**___ **POOR**___
- How do you rate your stress level? **HIGH**___ **MODERATE**___ **LOW**___
- Do you smoke? **YES/NO** Former Smoker? **YES/NO**
- Are you leading a sedentary lifestyle? **YES/NO**
- How long since you have participated in regular exercise? (at least 30 min three times / week)
  6-12 months **3-6 months** **currently exercising**
- Other information: Please list any other significant medical information you consider important for us to know _____

EMERGENCY: please list a person whom we may contact in case of an emergency.

Name:_____Phone_____Relation_____

APPLICANT'S SIGNATURE_____**DATE**_____

MEDICAL CLEARANCE (Renewable on a yearly basis):

I approve this patient for her/his participation in the Chicopee Council on Aging Fitness Program.

Please, indicate any specific guidelines or limitations for this patient:

_____

PHYSICIAN'S SIGNATURE:_____ DATE: _____

PHYSICIAN'S PRINTED NAME:_____ PHONE:_____

Please return to: Violet Suska, Health and Fitness Coordinator Fax: 413-557-6989

Chicopee Council on Aging 5 West Main St, Chicopee, MA 01020

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